MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

P.O. BOX 58
JEFFERSON CITY,
MO 65102-0058

INJURY NUMBER

NOTICE OF COMMENCEMENT/TERMINATION OF COMPENSATION

NOTE: THIS FORM MUST BE TYPED OR HAND PRINTED IN BLACK INK.

INSURER'S OR EMPLOYER'S NAME	CLAIM NO.
ADDRESS	ZIP CODE

THIS FORM NEEDS TO BE COMPLETED IF THE EMPLOYEE RECEIVED COMPENSATION BENEFITS AFTER THE THREE DAY WAITING PERIOD AND AS REQUIRED BY §§287.160, 287.170 AND 287.180, RSMo, AND 8 CSR 50-2.010. SEND ORIGINAL TO THE DIVISION AND ONE COPY TO THE EMPLOYEE.

TO EMPLOYER AND INSURER: BE SURE TO GIVE THE COST OF MEDICAL AID AND FURNISH ALL OTHER DATA ITEMS.

TO EMPLOYEE: THIS RECEIPT IS REQUIRED BY THE DIVISION OF WORKERS' COMPENSATION, AND YOU ARE REQUESTED TO SIGN IT IF IT COVERS THE PAYMENTS MADE TO YOU. YOUR SIGNATURE IS SIMPLY AN ACKNOWLEDGEMENT OF MONEY PAID AND DOES NOT CONSTITUTE A RELEASE.

(THIS FORM IS REQUIRED TO BE FILED WITHIN 30 DAYS OF THE DATE OF THE ORIGINAL NOTIFICATION OF THE INJURY. THIS FORM MUST BE UPDATED AND REFILED WITHIN TEN DAYS AFTER TERMINATION OF COMPENSATION.)

1. EMPLOYEE	1A. SOCIAL SECURITY NUMBER	2. DATE OF ACCIDENT	3. COST OF MEDICAL AID
4. EMPLOYEE ADDRESS			ZIP CODE

5. AVERAGE WEEKLY WAGE	6. RATE OF COMPENSATION	7. WAITING PERIOD DATES
$		

8. DISABILITY BEGAN	9. DISABILITY ENDED	10. TOTAL WEEKS OF COMPENSATION
		TEMPORARY TOTAL DISABILITY BENEFITS PAID TO DATE $
		TEMPORARY PARTIAL DISABILITY BENEFITS PAID TO DATE $
		IF EMPLOYEE WAS PAID FULL SALARY FOR ANY PERIOD OF DISABILITY, CHECK THIS BOX. ☐

11. NATURE OF DISABILITY

12. EMPLOYEE'S SIGNATURE

DISABILITY PAYMENT

13. DATE ACCIDENT REPORTED TO EMPLOYER	14. DATE FIRST PAYMENT WAS MADE TO EMPLOYEE	15. FIRST DAY OF PERIOD COVERED BY PAYMENT

NOTICE OF TERMINATION OF COMPENSATION

16. THIS IS TO NOTIFY THE **DIVISION OF WORKERS' COMPENSATION** AND THE EMPLOYEE THAT COMPENSATION PAYMENTS IN THE ABOVE MATTER HAVE TERMINATED, THE LAST PAYMENT HAVING BEEN MADE ON _____ 20____ FOR THE FOLLOWING REASONS _____

17. RETURN TO WORK DATE	18. PREPARED BY	
19. EMPLOYER'S OR INSURER'S SIGNATURE	20. DATE	21. PHONE NO.

DEATH BENEFIT PAYMENT

22. TO WHOM PAID	23. WEEKLY AMOUNT PAID

MEDICAL REPORT

(COMPLETE AFTER EVERY VISIT)

Division Injury Number

NOTE: THIS FORM MUST BE TYPED OR HAND PRINTED IN BLACK INK.

INJURED WORKER INFORMATION

1. NAME OF INJURED PERSON
   Last First
2. SOCIAL SECURITY NUMBER
   - -
3. DATE OF INJURY
4. NAME OF EMPLOYER
5. NAME OF INSURANCE CARRIER
6. DESCRIPTION OF HOW INJURY OCCURRED AS RELATED BY INJURED PERSON
7. DATE OF FIRST TREATMENT
8. BODY PART

TREATMENT INFORMATION

9. DESCRIBE TREATMENT GIVEN BY YOU
10. DID EMPLOYEE HAVE SURGERY? ☐ Yes ☐ No
11. HOSPITALIZATION?
    ☐ Yes ☐ No IF "YES," PROVIDE NAME AND ADDRESS OF HOSPITAL
    Admission Date
    Discharge Date
12. PHYSICAL REHABILITATION PRESCRIBED?
    ☐ Yes ☐ No
13. REFERRAL TO ANOTHER DOCTOR? ☐ Yes ☐ No IF "YES," NAME AND ADDRESS

RETURN TO WORK INFORMATION

14. DATE LOST TIME BEGAN FROM WORK
    ☐ RELEASED TO RTW WITHOUT PHYSICAL RESTRICTIONS
    ☐ RELEASED TO RTW WITH PHYSICAL RESTRICTIONS
    ☐ PERMANENT RESTRICTIONS
    ☐ TEMPORARY RESTRICTIONS – DURATION
15. DATE RELEASED TO RETURN TO WORK
    DESCRIBE THE RESTRICTIONS
16. IS ADDITIONAL MEDICAL TREATMENT NEEDED? ☐ Yes ☐ No IF "YES," PROGNOSIS
17. NEXT APPOINTMENT DATE
18. DOCTOR'S RATING IF ANY: _____ % *(percentage)* OF THE _____ *(body part)* AT THE _____ *(week level).*
19. TOTAL COST OF MEDICAL $ _____ IS THE FINAL COST. ☐ Yes ☐ No

PHYSICIAN INFORMATION

20. PHYSICIAN NAME *(Type or Print)*
    Last First
21. LICENSE NUMBER
22. PHYSICIAN ADDRESS
    CITY
    STATE
    ZIP CODE
23. PHYSICIAN SIGNATURE
24. TELEPHONE NUMBER
    ( ) -
25. DATE

ATTACH A BRIEF NARRATIVE WITH THE FINAL REPORT, IF APPROPRIATE.

The Division defines a "brief narrative" as the following "not to exceed a maximum of five (5) pages describing the course of treatment, the diagnosis, the evaluation for permanent injury and the need for future medical treatment, if any".